TASC

Technical Assistance and Services Center

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Topic: Framework for CAH Feasibility Studies, Initial Focus on Financial Feasibility Studies

Background

The Medicare Rural Hospital Flexibility Program (Flex Program), part of the Balanced Budget Act of 1997, is a nationwide limited service hospital initiative built on earlier demonstration models called Medical Assistance Facilities (MAFs) and Rural Primary Care Hospitals (RPCHs). The new program enables the development of critical access hospitals (CAHs), which are limited to 15 acute care beds and 96-hour average length of stay. Lead organizations have been identified in each participating state to guide the implementation of the Flex Program in that state. An integral part of the state Flex Program is the designation and support of the new critical access hospitals.

Determining whether CAH conversion is advisable is ultimately a community decision. The goal of a CAH conversion assessment is to gather information to make an informed decision about the future of the local hospital. Financial numbers are essential, but hospital leaders should also seek input from other health care providers and civic leaders in the service area. CAH conversion assessments often include an analysis of community need, the financial effect of conversion, and the clinical/administrative impact on hospital operations.

Across the country, Flex Program directors are taking different approaches to supporting CAH assessment studies. The creativity and diversity of approaches may be considered a strength of the program. Despite the diversity of approaches, assessment studies should answer a set of key questions including:

- How will conversion to CAH affect the community?
- How does cost reimbursement for Medicare compare to PPS payments? How will they compare in three years?
- How will conversion to CAH affect the medical staff of the hospital?
- How will conversion to CAH affect the operations of the hospital?
- What does the hospital need to do to position itself to convert to CAH status?

In December 1999, TASC convened a work group of technical advisors experienced in limited service hospital program implementation,[1] to identify the key components of a CAH assessment study, focusing first on the financial aspects of conversion and operation. The meeting led to a series of technical Briefings that TASC will disseminate to State Flex Programs. The first Briefing addressed the impact of the Balanced Budget Refinement Act; copies are available through the TASC office. Presented in a question and answer format, this Briefing is the second in TASC's series.

Questions and Answers

How can State Flex Programs utilize this Briefing?

The TASC work group acknowledges that State Flex Programs are along a broad spectrum in the direct support they are offering hospitals considering CAH designation. CAH assessments appear to be at the forefront of most State efforts. The following table summarizes how this Briefing may be used, depending on the existing status of planning and development (horizontal axis) and the implementation strategy (vertical axis).

	State Approach in Development	**State Approach Well-Developed**
Technical Assistance Used	• Use TASC Briefing information in writing RFP • Ensure consultants are proficient in suggested areas	• Use TASC Briefing information to improve existing process • Test consultant's work/approach/ products against suggestions
Staff Providing Support	• Use Briefing to help get started by better understanding the process • Use areas of Briefing to guide staff development and education	• Use TASC Briefing information to improve existing process • Re-evaluate ability to meet range of hospital needs

[1] Work group participants included: Jerry Coopey (Federal Office of Rural Health Policy), Bob Ellis (Westport Group), Brian Haapala (Northland Health Group), Terry Hill (National Rural Health Resource Center/TASC), Steve McDowell (Rural Health Consultants), Ann Miller (National Rural Health Resource Center/TASC), Paul Moore (Atoka Memorial Hospital), Eric Shell (Northland Health Group), Val Schott (Oklahoma Office of Rural Health), Tom Sipe (Kansas Hospital Association), Karen Travers (Westport Group), and Tony Wellever (Delta Rural Health). This briefing is based on the input and review of these experts. TASC has made every effort to represent the consensus opinions of this work group. This briefing may not represent the opinion of each participant.

What are the main components of a CAH assessment study?

Completing a financial assessment (i.e. calculating the immediate impact of CAH conversion and projecting future performance) is one part of a comprehensive CAH assessment. Other factors to consider in determining if CAH is a "good fit" include:

- Evaluating current and expected statistical/operational data
- Defining clinical service implications and/or opportunity for new product lines
- Determining community needs and health status
- Identifying opportunities for community development
- Understanding the level of existing and/or fostered professional buy-in

Do all hospitals need the same level of analysis?

No, the appropriate level of analysis is best matched to hospital-specific needs. The required level of analysis also varies from state to state. It is often useful to consider two major categories of hospitals:

- "Type A" hospitals are facilities that easily fit within the CAH guidelines. In general, these hospitals will have an average length of stay (LOS) of less than four days and an average daily census of 10 or less. For these hospitals, the decision to convert is made easier because very few (if any) clinical changes would be required to meet CAH guidelines. These hospitals would be expected to move through the CAH evaluation relatively quickly.

- "Type B" hospitals are generally larger facilities that may not have considered the CAH program without the change to a 96-hour average LOS. These hospitals will have an average daily census of 10 or more and an average LOS of more than four days. (Although there is no upper limit, most hospitals with an average daily census of 18 or more will likely not consider CAH.) Aside from management statistics, these facilities generally provide a different mix of primary and more complex types of care. Because of the additional complexity, CAH feasibility studies for these hospitals will take longer than their "Type A" counterparts.

Additional guidance on the finding the appropriate level of analysis is provided later in this Briefing.

What if the identified approaches are different than those in the State Rural Health Plan?

The TASC work group is not recommending that States need to revise their Rural Health Plan and re-submit it to HCFA for approval. We recognize each state has a unique set of constraints, and state plans require varying levels of detail from hospitals. This Briefing is not intended to suggest a prescriptive or inflexible approach.

TASC is providing this framework to States (and CAH-eligible hospitals) to encourage looking at the full range of issues that are important to successful CAH implementation. For example, hospitals are at risk of long-term failure if they focus solely on the financial aspects of CAH status without addressing broader strategic issues such as opportunities for networking or community development. Some of the approaches with a more long-term or strategic focus may be addressed after the CAH designation is achieved (e.g., developing a new strategic plan, looking into new services, etc.).

The analysis that is completed now will serve as the foundation for evaluating the impact of the change in the future. A more thorough analysis process will result in a broader base of information from which to judge the impact CAH status did or did not have.

We're helping the hospitals that need it most, but we feel there are a number of other hospitals that could also benefit from CAH designation. Do you have any suggestions on how I can get their attention and spread resources?

CAH is commonly perceived as a "downsizing" effort. Given the hospital's importance to the local economy and to community pride, it is reasonable to expect resistance in some communities. Research on the EACH/RPCH and MAF programs, however, indicate health services actually increase after conversion.

The TASC work group suggests framing the feasibility study as a strategic consideration for the future. For example, the mission of many rural hospitals relates directly to supporting a community-based continuum of services. Focusing on how the hospital can strategically adapt to the changing health care environment and best serve its community, positions the CAH conversion as a strategic alternative versus a "last resort" option for bailing out the facility. Finally, the administrator and/or board must be assured they have input into the conversion process and that they have the final decision regarding whether to convert to CAH. In other words, they can back out if the information collected does not support conversion.

Focusing limited state resources initially on those hospitals at greatest risk is a common and acceptable strategy in the short term. In general, though, the CAH program is not a panacea, and will not necessarily solve historic internal problems such as poor management or inadequate leadership. Therefore, states that offer broader planning, operational and leadership support may prove more successful in CAH conversion.

Right now our focus is primarily on financial aspects of CAH status. What are some methods of determining financial feasibility?

A CAH financial feasibility study is useful because not all small rural hospitals will benefit financially from CAH status. For example, some hospitals may have costs below the national averages and receive positive margins on Medicare inpatient care. These hospitals would only benefit from CAH if the future losses under outpatient prospective payment outweigh inpatient profits.

The following section outlines four alternative approaches to CAH financial feasibility analysis:

1. Preliminary Financial Screen
2. Multi Year Projection-Small Facility ("Type A")
3. Multi Year Projection-Large Facility ("Type B")
4. Product Line Projections for Small and Large Facilities

1. PRELIMINARY FINANCIAL SCREEN

Target Facility

- The small hospital that believes it will not extensively change its operations to accommodate the CAH restrictions or does not expect to change the services that it delivers will find this analysis helpful, but should not make major planning decisions based on its outcome.

Description

- The process involves a minimal effort of re-running of the most recent cost report with CAH parameters and then comparing historical reimbursement with estimated CAH reimbursement for the same period of time. This takes less than one full day of work, if prepared by an outside consulting firm. In some states, this has been done free of charge by Flex Program or hospital association staff.

Advantages

- The process can be completed quickly, which facilitates a rapid conversion (if appropriate for state requirements) at a low cost.

Disadvantages

- The results of this analysis may not provide an accurate picture for future hospital budget periods. This approach also fails to incorporate changes in hospital reimbursement or cost structure that: (a) may have occurred since the last cost report or (b) will be occurring over the next three to five years resulting from known regulatory, community, or operational changes.
- This method does not examine any changes or additions in future services.

Comments

- This type of analysis, if used exclusively, runs the risk of painting an inaccurate picture of CAH benefits or losses. It may be more appropriate to use this type of analysis as a means to facilitate a decision on whether or not to go forward with a more sophisticated CAH analysis. However, depending upon the requirements of individual states, this may be sufficient to complete the application process.

2. MULTI YEAR PROJECTION-SMALL FACILITY ("TYPE A")

Target Facility

- The small hospital that believes it is not going to have to change its operations very extensively to accommodate the CAH restrictions or does not expect to change the services that it delivers may find this type of analysis useful in the CAH application process. This facility would be likely to have some small change in space and other overhead utilization statistics, but would not make major changes to its operations as a result of CAH conversion.

Description

- Financial personnel completing these studies should include a financial impact analysis report that describes the assumptions and presents an income and expense statement for the base year and at least three years of projections. It is important that different assumptions be separated in the final report. For example, if a hospital wants to convert to CAH and also convert its outpatient clinic to rural health clinic status, the impact of these two separate events should not be combined in a way that blurs the impact of either action independently.

- This analysis should take into consideration the changes in operations that will occur as a result of participation in the CAH program. This includes reduction in numbers of acute care beds or increased numbers of swing beds. Required data includes the most recent hospital cost report plus supporting data and information on which to base anticipated changes in inpatient and outpatient utilization. Changes resulting from normal annual cost of living increases and other anticipated changes in costs, or basic changes in patient service utilization, should also be part of this analysis.
- About four to five days of consultant effort would be normal for this type of study. Additional time may be required to present the results to a board of directors and/or medical staff.

Advantages

- This type of analysis is relatively straightforward and should provide a viable answer to the question of whether to convert to CAH.

Disadvantages

- This analysis may not provide an insight into the financial feasibility of various new product line opportunities that may be available to the new CAH as a result of its enhanced Medicare and, possibly, Medicaid reimbursement. It also is moderately expensive.

Comments

- This analysis will provide a fairly good indication of how CAH enhanced reimbursement will impact the hospital in the near future if the facility generally maintains a "business as usual" operating plan. Significantly expanding or contracting services will cause this type of analysis to project inaccurate outcomes.

3. MULTI YEAR PROJECTION-LARGE FACILITY ("TYPE B")

Target Facility

- The larger facility that has an average daily census high enough to experience problems with the 15 acute care bed limit, might perform this type of analysis to determine the appropriateness and timing of CAH conversion. Such an analysis should also consider expanded services, utilization of swing beds and, as appropriate, transfers to larger facilities.

Description

- This type of analysis should take into consideration changes in operations that will occur as a result of participation in the CAH program. This includes reduction in numbers of acute care beds or increased numbers of swing beds and corresponding changes in revenue, costs and utilization.
- Multi-year projections are key to providing insight into the future impact of the CAH on the hospital's bottom line. In addition, this type of analysis is important to determine the timing of CAH conversion or future expansion or contraction of services for facilities that may not presently be able to reduce services to the 15 acute care bed limit.
- A consultant that works with a facility to produce this type of analysis should be expected to work closely with administration in order to prepare an accurate set of assumptions. Assumptions should be reviewed with medical staff leaders as hospital-specific circumstances dictate.
- Hospitals of this size often work best with a two-step process: a preliminary and a final report. The preliminary report may incorporate assumptions that will need to be modified for the final report depending upon input from the board of directors. Because conversion to CAH may have an impact on the admission and care practices of the medical staff, it is important that physicians also be included in the process of developing financial assumptions.
- This analysis is relatively extensive and could require several weeks of professional time, depending upon utilization and the timing associated with conversion to CAH status. Working with the hospital board and medical staff to develop acceptable sets of assumptions may require additional time and effort.

Advantages

- This process for involving the administration, medical staff, and others will help facilitate the greatest degree of acceptance by all parties involved.
- This type of analysis will provide years of guidance to the hospital's Board, medical staff and administration regarding the impact and timing of conversion to CAH status. In addition, the outcomes of this analysis will provide the basis for further strategic planning, by providing valuable insight into the financial feasibility of service expansion, primarily on the outpatient side of the hospital.

Disadvantages

- This is the most expensive and time-consuming type of analysis. It will benefit from outside expertise experienced in limited service hospital reimbursement.

Comments

- This analysis may be desirable if a facility is relatively large and may be adversely affected by the 15 acute care bed limit or the 96-hour average length of stay. As a result of the process, the hospital should gain a better understanding of why and when to convert to CAH status. Since the process, which models known reimbursement changes such as the Sole Community Hospital rate enhancement, hospitals will also better understand their financial outlook whether or not they convert to CAH.

4. PRODUCT LINE PROJECTIONS FOR SMALL AND LARGE FACILITIES

Target Facility

- Large and small hospitals that have performed the multi-year analysis described in the two previous sections may find the information helpful in developing "product lines." The analysis can also be used to complement a community needs assessment. After potential services have been identified, this analysis examines the financial impact of adding these services to a facility's "product line," as well as determining the appropriate timing for adding these services.

Description

- In addition to the products described in the large and small hospital analyses sections, the strategic planning analysis should present the financial impact and implementation timing associated with each new service examined. The recommendations of this report should be very carefully worded, depending upon the scope of the project.
- The analysis should take into consideration the changes in operations that will occur as a result of participation in the CAH program. This might include reduced numbers of acute care beds or an increased number of swing beds. Service expansion, particularly on the outpatient side of a hospital's operations, will play a major role in the facility's future viability.
- Multi-year projections are key to determining the future financial impact of CAH conversion. In addition, this type of analysis will help to determine the timing of CAH conversion, including expansion or contraction of services for facilities that may not presently be able to reduce services to meet the 15 acute care bed limit.

- With information from the product line analysis, the potential CAH should be able to project the most likely conversion timetable, as well as the timetable for developing additional product lines.

Advantages

- This type of analysis will provide years of guidance to the hospital's board, medical staff and administration regarding the impact and timing of CAH conversion. In addition, insight into the financial feasibility of service expansion (primarily on the outpatient side of the hospital) can help the hospital to reduce out migration for health services and improve its negotiating position with managed care organizations.
- This report may also provide the impetus for continuing discussions with other area health care providers that might lead to formal network development and service integration.

Disadvantages

- This analysis requires considerable CAH knowledge and expertise to ensure that all aspects of the CAH enhanced reimbursement are incorporated into the final analysis.
- It can be relatively expensive.

Comments

- Both the large and small facilities would benefit from this type of analysis if significant changes in services or product lines are anticipated. While this is often the result of outpatient service expansion, it is also relevent for facilities that need to contract inpatient or outpatient services. Understanding the financial impact of these changes is crucial for facilities that plan to make significant service changes as a result of converting to CAH. Understanding the implications of the timing of service expansion or CAH conversion is just as critical.
- While some may consider this type of analysis beyond the scope of the required financial feasibility analysis required as part of the CAH conversion process, such an analysis will provide boards, medical staffs and administrators with a measuring stick that will provide significant payback over time.

Why do many financial advisors recommend three to five-year projections when things are changing so rapidly?

The Balanced Budget Refinement Act specified a number of changes to hospital reimbursement that will be phased in over time. For example, the re-basing of Sole Community Hospitals will take place over the next four years. Short-term projections will not show the full impact of this change and, as a result, may overstate the benefit of CAH.

As long at the operating assumptions used in the different scenarios are held constant (i.e., same FY 2002 assumptions are used in the base model and the CAH model), then any financial differences between the models will be because of differences in the cost-based and prospective payment reimbursement systems.

What should I expect future TASC Briefings to address? How long will TASC provide this type of information?

Central to the purpose of TASC is disseminating useful information to State Flex Programs. We expect to continue publishing the Briefing series as long as States find them useful and informative. If you have specific feedback regarding the content, style, or direction of this series, please do not hesitate to contact Terry Hill or Ann Miller at (218) 720-0700.

We have tried to sequence the TASC Briefings in response to the needs of the States. This Briefing lays out a framework for comprehensive CAH assessment and implementation process, but focuses primarily on the financial aspects of the framework. Future Briefings will focus on other aspects of the CAH implementation process, including community assessments, quality assurance, and network development.